Form 123 Revised 4/05

PHYSICIAN'S INITIAL REPORT OF WORK INJURY OR OCCUPATIONAL DISEASE

This report must be filed pursuant to rule R612-2-3-(A)

For your protection Utah law requires notificaton that any workers' compensation fraudulent claim for disability compensation or medical benefits is a crime and may be subject to fines and confinement in the state prison.

State of Utah – Labor Commission - Division of Industrial Accidents
160 East 300 South, P.O. Box 146610, Salt Lake City, Utah 84114-6610

PLEASE PRINT OR TYPE

Insurance Company:

Address:

Do Not Use This Space
CLAIM NO.
POLICY NO.
Class Code.

PATIENT

1. Employee's First Name: / Nombre de el/la Empleado/a: | Middle Initial: / Inicial de 2do Nombre | Last Name: / Apellido
2. Social Security No. / No. de Seguro Social
3. DOB: / Fecha de Nacimiento
4. Sex: / Sexo:
5. Mailing Address: / Direccion de Correo: | City: / Ciudad: | State: / Estado: | Zip: / Codigo Postal:
6. Phone No.: / No. de Tel:
7. HT: / Estatura:
8. WT: / Peso:
9. Name of Employer: / Compania donde Trabaja:
10. Mailing Address: / Direccion de Correo:
11. Phone No.: / No. del Tel:

HISTORY

12. Date Injured: / Fecha del Accidente: | Hour: / Hora: | AM ☐ PM ☐
13. Last Date Worked: / Ultimo Dia que Trabajo:
14a. Has This Part Been Injured Before? / Se ha Lastimado esta Parte Antes? YES ☐ NO ☐
14b. If "Yes" State When and Describe: / Si Contesto "Si" describa Cuando Y Como:
15. Employee's Statement of Cause of Injury or Illness (In First Person): / Describa en sus Propias Palabras la Cause de el Accidente o Enfermedad (en 1ra Persona)
16. Describe Complaints (In First Person): / Describa Sus Quejas (en 1er Persona):

EXAMINATION

17. Findings of Examination:
18. X-Rays? Yes ☐ No ☐ / Findings:
19. ICD-9 Codes: ___ ___ ___ - ___ ___
20. Diagnosis (Written Description):
21. Is the Condition Requiring Treatment the Result of the Industrial Injury or Exposure Described? Yes ☐ No ☐ Undetermined ☐ If "No" Explain:

TREATMENT

22. Date of First Treatment: Hour: AM ☐ PM ☐
23. Type of Treatment:
24. If Hospitalized, What Hospital? In-Patient ☐ Out-Patient ☐
25. If Case Referred to Another Physician, Give Physician's Name and Address

DISPOSITION

26. Is Condition Medically Stationary? Yes ☐ No ☐
27. Is Any Further Treatment Required? Yes ☐ No ☐ If "Yes" Date of Next Visit and How Many Estimated?
28. Will Injury Cause Permanent Impairment? Yes ☐ No ☐
29. Does Injury Prevent Return to Regular Employment? Yes ☐ No ☐ If "yes" Estimate Time Loss: Modified Employment Yes ☐ No ☐ If "Yes" Explain Restrictions:
30. Date Released for Work:
31. Remarks or Outline of Proposed Treatment:
32. Are there Any Conditions That Would Retard or Prevent Recovery? Yes ☐ No ☐

33. Name of Physician and Degree:
34. Address:
35. Phone No.
36. Federal Tax I.D. Number:
37. Date:
38. Signature (Physician's Own Signature Please):

White: Insurance Carrier **Yellow:** Labor Commission **Pink:** Employee **Goldenrod:** Physician's File